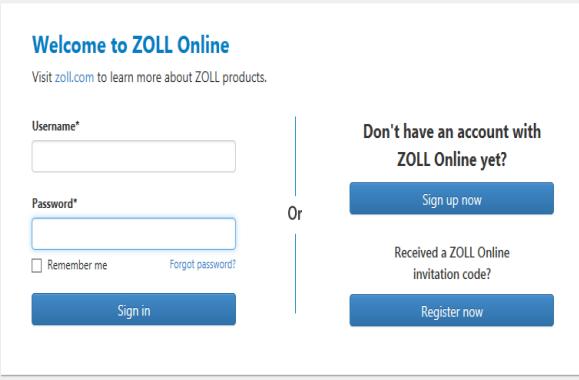


Mobile Care

Connect Training



The image shows the ZOLL Online login page. At the top, it says "Welcome to ZOLL Online". Below that, there's a note: "Visit zoll.com to learn more about ZOLL products." The login form has fields for "Username*" and "Password*". There are checkboxes for "Remember me" and "Forgot password?". A "Sign in" button is at the bottom of the form. To the right, there's a vertical line with the text "Or" in the middle. Above the line, it says "Don't have an account with ZOLL Online yet?" and below it is a "Sign up now" button. Below the line, it says "Received a ZOLL Online invitation code?" and below that is a "Register now" button. At the very bottom of the page, there's small text: "© 2017 ZOLL [Terms of Service](#) | [Privacy Policy](#) | [Security](#) | [Get Help](#)" and "v.6.7.0.23 - [www.zollonline.com]".

To begin - log into
<https://www.zollonline.com>
and sign-in with your
Username* and Password*

ZOLL Admin Company: Spirit Medical Transport Jennifer Sullivan Logout

Mobile Care Connect Schedule transport User settings Admin @Work

Scheduled by: Van Wert County Hospit... Ordering facility: All facilities Inbound/Outbound: All Active filters: Status: 9 call types. Calendar loaded: 08/01/2017 15:40:48 - Eastern

Jul 30 – Aug 5 2017 Month Week Day

Sun 7/30	Mon 7/31	Tue 8/1	Wed 8/2	Thu 8/3	Fri 8/4	Sat 8/5

Choose Schedule Transport to begin.

You may view the calendar by Month, Week, or Day

Today's date will be highlighted in yellow

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v.6.7.0.39

Mobile Care Connect Schedule transport User settings Admin @Work

Complete as much information as possible – all asterisk* fields must be completed.

Transport details

One-way Round trip

Pick-up date/time: 08/31/2017 20 : 30 Will call :

Priority*: Pre-Scheduled Call type*: BLS Nature*: Doctors Apppt

Complaint: ABDOMINAL PAIN - 789.00 Ordering facility*: Van Wert County Hospital Association CAD company: Spirit Medical Transport LLC

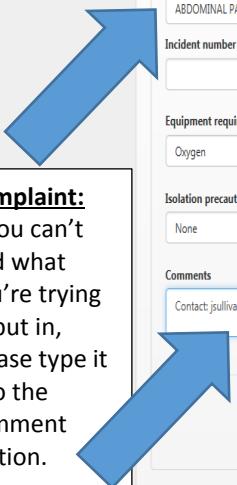
Incident number:

Equipment requirements: Oxygen Other equipment: 3 Liters N/C

Isolation precautions: None Other isolation precautions:

Comments: Contact: jsullivan@spiritmedicaltransport.com Jennifer Sullivan

Complaint:
If you can't find what you're trying to put in, please type it into the comment section.

**Priority*:****Emergency** – patient needs to go to the ER right now, lights and sirensPLEASE CALL US IMMEDIATELY, **do not** enter this type of call system**Immediate** - transport is needed today, but is not an emergency**Prescheduled** - Doctor Appointments or Outpatient Procedures scheduled for future dates**Call Type*:****ALS - Advanced Life Support** – This is when a Paramedic is required. This is for patients that have an IV.**ALS BARIATRIC** - For patients weighing over 400 lbs.**BLS - Basic Life Support - EMT**. This is for a stretcher transport not requiring anything but at the most Oxygen.**BLS BARIATRIC** - For patients weighing over 400 lbs.**WHEELCHAIR** - For a patient who requires a wheelchair transport to their appointment or procedure**WHEELCHAIR DISCHARGE TO NURSING HOME** - For a patient who requires a wheelchair transport that is going to another nursing home.**WHEELCHAIR DISCHARGE TO RESIDENCE** - For a patient who requires a wheelchair transport that is returning home.**Nature*:****Doctor Appointment****Outpatient Procedure**

Mobile Care Connect Schedule transport User settings Admin @Work

Transport details

 One-way Round trip

Pick-up date/time

08/31/2017 20 : 30

 Will call

Appointment time

Hour : Minute

Priority*

Pre-Scheduled

Call type*

BLS

Nature*

Doctors Apppt

Complaint

ABDOMINAL PAIN - 789.00

Ordering facility*

Van Wert County Hospital Association

CAD company

Spirit Medical Transport LLC

Incident number

Equipment requirements

Oxygen

Other equipment

3 Liters N/C

Isolation precautions

None

Other isolation precautions

Comments

Contact: jsullivan@spiritmedicaltransport.com Jennifer Sullivan

Cancel Next >

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS;
THEN COPY AND PASTE INTO THE COMMENT SECTION SHOWN ABOVE:

1. Will your facility be responsible to pay for the incurred costs of this transport? **[i.e. Yes, Patient is skilled]**
2. What medical conditions with the patient currently exist which require the patient to be transported by (ambulance, wheelchair) and inadvisable to transport the patient by any other means? **[i.e. Weakness; Fall Risk; Unsteady Gait; on O2]**
3. If stretcher: Does the patient meet bed confinement criteria meaning they meet ALL of the following criteria: They are unable to get out of bed without assistance; unable to ambulate, and unable to safely sit in a wheelchair? **NO**
 If yes, what medical condition is this related to?
4. What is the medical condition the patient has that he/she will be seen for? **[Please be specific – “Follow-up” does not have an ICD-10 diagnosis code. i.e. Chemo Therapy: Throat Cancer]**
5. What type of physician specialist/procedure is this? **[i.e. Outpatient]**
6. What is the full first and last name of the ordering physician and his/her credentials? **[i.e. Dr. Thomas Brown MD]**

If a stretcher or wheelchair is going to a personal residence: Are there any steps that the crew will have to maneuver to safely get the patient into the residence? If yes, how many?

Then click **Next>**

Put in the patient's complete first and last name, then their date of birth. Then click on search. If the patient is in your data base, it should pre-fill the rest of the patient's information in the blanks. Please confirm that all the auto-filled information is current. Please correct anything that needs updated. If this is a first time patient, then complete all the required information.

The screenshot shows a software interface for 'Mobile Care Connect' from 'ZOLL'. At the top, there is a navigation bar with 'Admin' and 'Company: Spirit Medical Transport'. On the right, there are buttons for 'Jennifer Sullivan' and 'Logout'. Below the navigation bar, there is a sub-navigation menu with 'Mobile Care Connect', 'Schedule transport', 'User settings', 'Admin ▾', and '@Work'. A yellow message box at the top center says 'Patient search was successful - address was auto-filled.' A close button 'X' is located in the top right corner of this message box. The main content area is titled 'Patient details'. It contains several input fields: 'First name*' with value 'DEBORAH', 'Last name*' with value 'HATHAWAY', 'Date of birth*' with value '6/6/1956', and a 'Social security number' field which is empty. Below these, there is a section for 'Search for patient' with 'Search' and 'Clear Search' buttons. There are also fields for 'Address*', 'Address 2', 'City*', 'State*', 'Postal code*', 'Phone*', 'Stairs at residence' (with an unchecked checkbox), and 'Patient weight' (with a dropdown menu showing '[Select]'). At the bottom right of the form, there are buttons for 'Cancel', '< Previous', and 'Next >'. At the very bottom of the page, there is a footer with links to '© 2017 ZOLL | Terms of service | Security | Get help' and the text 'v67.039'.

Then click **Next >**

ZOLL Admin Company: Spirit Medical Transport Jennifer Sullivan Logout

Mobile Care Connect Schedule transport User settings Admin @Work

Current insurance payers

Payer	Phone
Bill Patient	(937) 000-0000 Ext.
ANTHEM BLUE CROSS BLUE SHIELD	(888) 290-9160 Ext.

Add Insurance

Payers Selected payer to add

Member ID Group ID

Guarantor

Subscriber

Address Address 2

City State

Postal code Phone

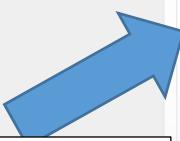
Insurance information should prefill here if this is a previous patient. If the facility is the payor, please add your information. Please confirm all information is current and correct.



Then click **Next >**

[Mobile Care Connect](#) [Schedule transport](#) [User settings](#) [Admin ▾](#) [@Work](#)

Pick Up Location:
If you are the
Ordering Facility,
just click on that
field and it will
prefill your
information.
**Please add the
patient's room
number to ensure
our crew knows
exactly where to
pick the patient
up.**



Pick-up location

Search facilities Ordering facility Patient residence

Location name

[Clear Search](#)

Address* Apt/Suite/Room #
Requires RNB 4.6.1

Additional pick-up address info

This goes to CAD notes

City* State*

Postal code* Phone*

[Cancel](#) [< Previous](#) [Next >](#)

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Then click **Next >**

ZOLL Admin Company: Spirit Medical Transport Jennifer Sullivan Logout

Mobile Care Connect Schedule transport User settings Admin @Work

Drop-Off

Location: Search Facilities; Put in the name of the facility the patient will be going to. If it's in the database, it will prefill the address and phone number.

Please add the Suite Number if you have it. This will ensure the crew takes the patient to the exact location they need to be.

Drop-off location

Search facilities Ordering facility Patient residence

Location name: VAN WERT MEDICAL SERVICES

Clear Search

Address*: 140 FOX RD

Apt/Suite/Room #: STE 401
Requires RNDB 4.6.1

Additional drop-off address info

This goes to CAD notes:

City*: VAN WERT

State*: OH

Postal code*: 45891

Phone*: (419) 232-5291 Ext.

Cancel < Previous Next >

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v8.7.0.39



Then click **Next >**

ZOLL Admin Company: Spirit Medical Transport Jennifer Sullivan Logout

Mobile Care Connect Schedule transport User settings Admin @Work

Transport summary

Transport Pick-up time: 08/31/2017 20:00 Appointment time: 21:00 CAD company: Spirit Medical Transport LLC Ordering facility: Van Wert County Hospital Association Priority: Pre-Scheduled Call type: BLS Nature: Doctors Apppt. Complaint: ABDOMINAL PAIN - 789.00 Incident number:

Comments

Contact: jlullivan@sprintmedicaltransport.com Jennifer Sullivan
Equipment requirements: Oxygen, 3 Liters N/C
Patient weight: 91-199 lbs

Patient Name: DEBORAH HATHAWAY SSN: Date of birth: 6/6/1956 Address: 976 NORTH OHIO ST GREENVILLE, OH 45331-2917 (937) 548-3260 Ext. Weight: 91-199 lbs

Pick-up address [Van Wert County Hospital Association] 1250 S WASHINGTON ST VAN WERT, OH 45891-2551 (419) 238-2390 Ext.

Drop-off address [VAN WERT MEDICAL SERVICES] 140 FOX RD, STE 401 VAN WERT, OH 45891 (419) 232-5291 Ext.
Apt/Suite/Room #: STE 401

PCS user notifications
Select users for PCS notification

None

File attachments

Attach a file

Cancel < Previous Finish

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v.67.0.39



A large blue arrow points from the left side of the screen towards the transport summary section of the software interface.

Transport Summary:
Review the information you've added.
Edit any corrections that may need to be completed.

Then click **Next>**

Mobile Care Connect Schedule transport User settings Admin @Work

Transport summary

Transport Pick-up time: 08/31/2017 20:30 Appointment time: 21:00 CAD company: Spirit Medical Transport LLC Ordering facility: Van Wert County Hospital Association Priority:

Pre-Scheduled Call type: BLS Nature: Doctors Appt Complaint: ABDOMINAL PAIN - 789.00 Incident number:

Comments

Contact: jsullivan@spiritmedicaltransport.com Jennifer Sullivan
Equipment requirements: Oxygen, 3 Liters N/C
Patient weight: 91-199 lbs

Patient Name: DEBORAH HATHAWAY SSN: Date of birth: 6/6/1956 Address: 976 NORTH OHIO ST GREENVILLE, OH 45331-2917 (937) 548-3260 Ext. Weight: 91-199 lbs**Pick-up address** [Van Wert County Hospital Association] 1250 S WASHINGTON ST VAN WERT, OH 45891-2551 (419) 238-2390 Ext.**Drop-off address** [VAN WERT MEDICAL SERVICES] 140 FOX RD, STE 401 VAN WERT, OH 45891 (419) 232-5291 Ext.

Apartment/Suite/Room #: STE 401

PCS user notifications

Select users for PCS notification

(Hathaway, Brian)

 (Hathaway, Brian)

File attachments

 Attach a file

Cancel

< Previous

Finish

PCS USER NOTIFICATIONS: check mark the name of the person who will be signing the PCS (Medical Necessity Form)

FILE ATTACHMENTS: Attach a file: File Type – Choose what you are attaching from the drop down menu.

Upload an attachment – File type* - Select what you are attaching. The FaceSheet, Medication List, DNR, etc. is what we are looking for here.

The screenshot shows the ZOLL Mobile Care Connect software interface. At the top, it says "Company: Spirit Medical Transport". On the left, there's a sidebar with "Mobile Care Connect", "Schedule transport", "User settings", "Admin", and "@Work". The main area shows a "Transport summary" with details like "Call up time: 08/01/2012", "Scheduled Call type: BLS", "Nature: Non-emergency", and "Comments" including contact info and patient weight. A large blue arrow points from the sidebar down to the "File attachments" section. In this section, there's a "File type*" dropdown menu open, showing options like "Select...", "DNR/Living will", "Patient identification", "Physician's certification statement/PCS form", and "Other (not listed)". Below the dropdown are "Save" and "Cancel" buttons. Further down, there's a "PCS user notifications" section with a dropdown menu containing "(Hathaway, Brian)" and "File attachments" with a "Attach a file" button and a text input field. At the bottom right are "Cancel", "< Previous", and "Finish" buttons. The footer includes copyright information and a version number "v8.7.0.39".

ZOLL Admin Company: Spirit Medical Transport

Mobile Care Connect Schedule transport User settings Admin @Work

Transport summary

Transport Pick-up 01/21/2012 Pre-Scheduled C C van@spiritmedicaltransport.com Equipment requirements: Oxygen, 3 L Patient weight: 91-199 lbs

Patient Name: DEBORAH HATHAWAY SSN: Date of birth: 6/6/1956 Address: 976 NORTH OHIO ST GREENVILLE, OH 45331-2917 (937) 548-3260 Ext. Weight: 91-199 lbs

Pick-up address [Van Wert County Hospital Association] 1250 S WASHINGTON ST VAN WERT, OH 45891-2551 (419) 238-2390 Ext.

Drop-off address [VAN WERT MEDICAL SERVICES] 140 FOX RD, STE 401 VAN WERT, OH 45891, (419) 232-5291 Ext.
Apartment/Suite/Room #: STE 401

Upload an attachment

File type* Patient identification

Select a file to upload... \\Smtserver\scanner\FACE SF Browse...

Save Cancel

Search your database for the attachment you want to attach.

PCS user notifications

Select users for PCS notification (Hathaway, Brian)

File attachments

Attach a file

Cancel < Previous Finish

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Then click **Save**

ZOLL Admin Company: Spirit Medical Transport Jennifer Sullivan Logout

Mobile Care Connect Schedule transport User settings Admin @Work

Transport summary

Transport Pick-up time: 08/31/2017 20:30 Appointment time: 21:00 CAD company: Spirit Medical Transport LLC Ordering facility: Van Wert County Hospital Association Priority: Pre-Scheduled Call type: BLS Nature: Doctors Apppt Complaint: ABDOMINAL PAIN - 789.0 Incident number:

Comments

Contact: jsullivan@spiritmedicaltransport.com Jennifer Sullivan
Equipment requirements: Oxygen, 3 Liters N/C
Patient weight: 91-199 lbs

Patient Name: DEBORAH HATHAWAY SSN: Date of birth: 6/6/1956 Address: 976 NORTH OHIO ST GREENVILLE, OH 45331-2917 (937) 548-3260 Ext. Weight: 91-199 lbs

Pick-up address [Van Wert County Hospital Association] 1250 S WASHINGTON ST VAN WERT, OH 45891-2551 (419) 238-2390 Ext.

Drop-off address [VAN WERT MEDICAL SERVICES] 140 FOX RD, STE 401 VAN WERT, OH 45891 (419) 232-5291 Ext.
Apt/Suite/Room #: STE 401

PCS user notifications
Select users for PCS notification
[Hathaway, Brian]

File attachments

Attach a file

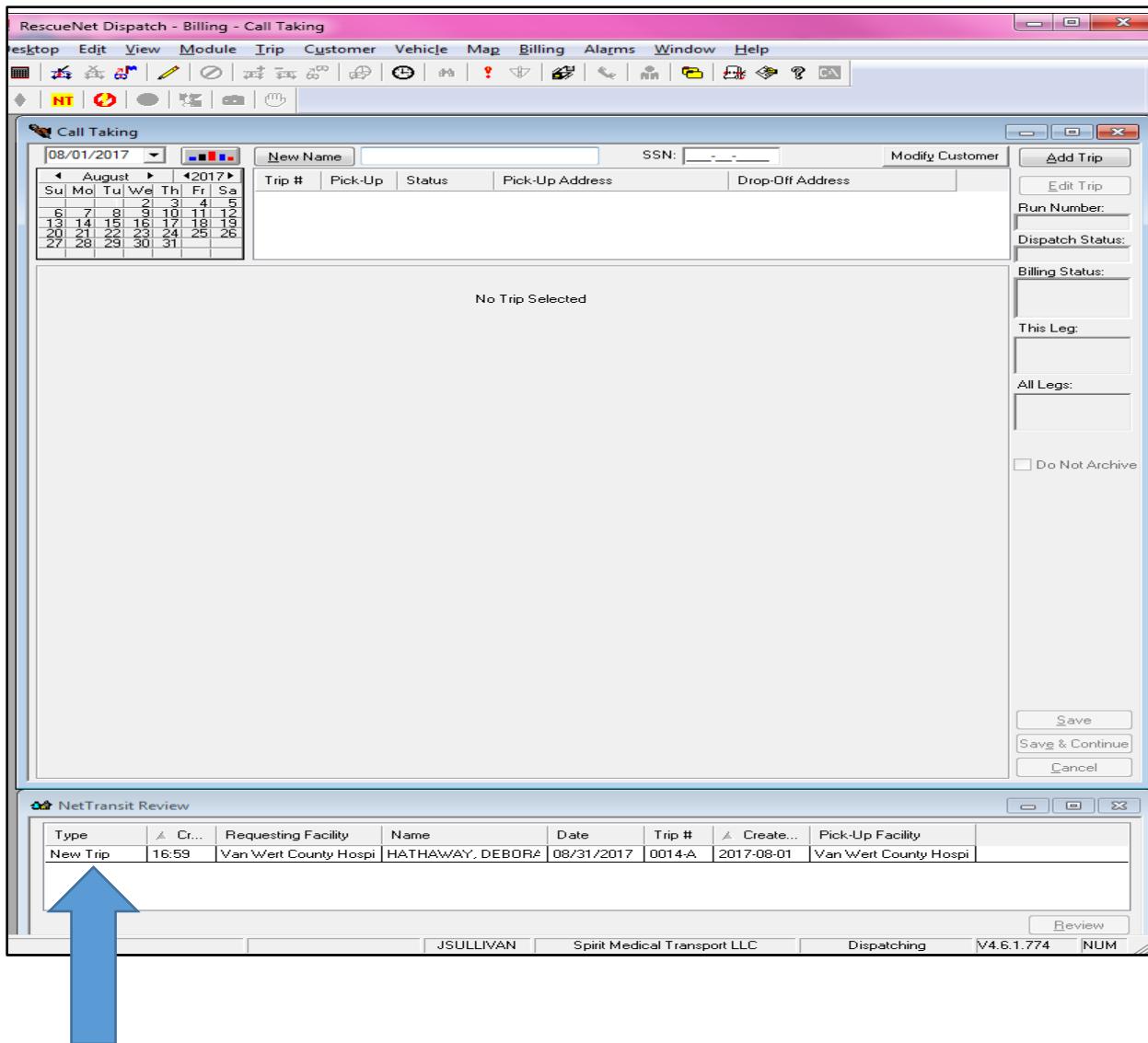
File	File type	Uploaded	User	Delete
ABBOTT, WILLIAM 01112017.pdf	Patient identification	8/1/2017 12:57 PM	Jennifer Sullivan [sullivan@spiritmedicaltransport.com]	X

Cancel < Previous Finish

TRANSPORT SUMMARY: File Attachments now shown.



Then click **Finish**



The transport will then pop into our data base for us to review and accept. If you have set up to receive emails or texts regarding this transport, you'll receive a notification from me that I've either accepted the transport, I've made notes to you concerning any additional information needed, or changes that I need to make to the requested scheduled. This may be a change in the pickup time, for example.

You will next receive an email stating the PCS (Medical Necessity Form) is ready to be signed. When you click on the link, it will bring up the PCS. You can electronically sign it and it will attach automatically to the scheduled transport.



Physician Certification Statement (PCS) for ambulance transport

Patient name:

Date of transport: 7/18/2017

Pick-up location: WAYNE HEALTHCARE [dba] - Emergency Department; 835 SWITZER ST - ed 3, GREENVIL

Drop-off location: Good Samaritan Hospital & Health Center; 2222 PHILADELPHIA DR - RM 5344, DAYTON, OH

Patient DOB:

Weight: 91-199 lbs

SSN:

Patient address:

, New Paris, Oh, 45347

Equipment requirements: IV

Isolation precautions:

Contact person: Caitlin Kelly

The actual PCS (Medical Necessity Form) will include all of the patient's demographic information.

Medical necessity section:

- (1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:
patient has a liver mass and thrombus IVC - needs higher level of care

- (2) Is this patient "bed confined" as defined below?

To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.

- (3) Please check any of the following conditions that apply:

Note: supporting documentation for any boxes checked must be maintained in the patient's medical records

- Patient is confused/combative/comatose
- Danger to self/other
- IV meds/fluids required
- Requires oxygen – unable to self administer
- Special handling/isolation/infection precautions required
- Cardiac monitoring required enroute
- Morbid obesity requires additional personnel/equipment

This PCS (Medical Necessity Form) is for all ambulance transports
EXCEPT Medicaid and Medicaid HMO covered patients.

I certify that this information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

Signed by: CAITLIN KELLY

Signature Date: 7/18/2017

Job Title: Discharge Planner

Signature:



Ohio Department of Medicaid
CERTIFICATION OF NECESSITY
FOR NON-EMERGENCY TRANSPORTATION
BY GROUND AMBULANCE

Individual Information

1. Name <i>(Enter the full name of the individual transported.)</i>	2. Ohio Medicaid Billing Number — <i>12 Digits</i>
3. Address <i>(Enter the individual's home address. This information may be used to confirm the identity of the individual.)</i>	

Transportation Provider Information

4. Provider Name <i>(Enter the business name of the transportation provider.)</i> SPIRIT MEDICAL TRANSPORT, LLC	
5. Ohio Medicaid Provider Number — <i>7 Digits</i> 2740421	6. National Provider Identifier (NPI) — <i>10 Digits</i> 1326121104

Certification

7. Criteria <i>(Mark each reason why transport is being certified as necessary for this individual.)</i> During transport, this individual requires: <input checked="" type="checkbox"/> medical treatment or continuous supervision by an EMT. <input type="checkbox"/> the administration or regulation of oxygen by another person. <input type="checkbox"/> supervised protective restraint.	8. Period Beginning Date <i>(Enter the first date of the certification period.)</i> 9. Length <i>(Mark one box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)</i> <input type="checkbox"/> Not more than 1 day(s) <input type="checkbox"/> One year
--	---

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

Certifying Practitioner Information

11. Name of Practitioner <i>(Enter the full name of the certifying practitioner.)</i>	
12. Ohio Medicaid Provider Number, If Applicable — <i>7 Digits</i>	13. National Provider Identifier (NPI) — <i>10 Digits</i>

Signature Information

14. Date of Signature	15. Name of Person Signing
16. Signature and Professional Designation <i>(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)</i>	

False certification constitutes Medicaid fraud.

This form confirms the certification of one individual for transport by one service provider; certification is not transferrable between individuals or service providers. A photocopy, an electronic copy, or a facsimile transmittal of the completed, signed, and dated certification form is as valid as the original for documentation purposes. Completion of this form is required in accordance with Chapter 5160-15 of the Ohio Administrative Code.

ODM 01960 (Rev. 7/2015)

This PCS (Medical Necessity Form) is for ambulance transports scheduled for Medicaid and Medicaid HMO covered patients.



Ohio Department of Medicaid
**CERTIFICATION OF NECESSITY
FOR TRANSPORTATION
BY WHEELCHAIR VAN**

Individual Information

1. Name <i>(Enter the full name of the individual transported.)</i>	2. Ohio Medicaid Billing Number — 12 Digits
3. Address <i>(Enter the individual's home address. This information may be used to confirm the identity of the individual.)</i>	

Transportation Provider Information

4. Provider Name <i>(Enter the business name of the transportation provider.)</i> SPIRIT MEDICAL TRANSPORT, LLC	
5. Ohio Medicaid Provider Number — 7 Digits 2737767	6. National Provider Identifier (NPI), If Applicable — 10 Digits 1326121104

Certification

7. Criteria <i>By signing this document, the practitioner certifies that two statements are true:</i> a. This individual must be accompanied by a mobility-related assistive device from the point of pick-up to the point of drop-off. b. Transport of this individual by standard passenger vehicle or common carrier is precluded or contraindicated.	8. Period Beginning Date <i>(Enter the first date of the certification period.)</i>
	9. Length <i>(Mark one box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)</i> <input type="checkbox"/> Not more than 1 day(s) <input type="checkbox"/> One year

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

Certifying Practitioner Information

11. Name of Practitioner <i>(Enter the full name of the certifying practitioner.)</i>	
12. Ohio Medicaid Provider Number, If Applicable — 7 Digits	13. National Provider Identifier (NPI) — 10 Digits

Signature Information

14. Date of Signature	15. Name of Person Signing
16. Signature and Professional Designation <i>(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)</i>	

False certification constitutes Medicaid fraud.

This form confirms the certification of one individual for transport by one service provider; certification is not transferrable between individuals or service providers. A photocopy, an electronic copy, or a facsimile transmittal of the completed, signed, and dated certification form is as valid as the original for documentation purposes. Completion of this form is required in accordance with Chapter 5160-15 of the Ohio Administrative Code.

ODM 03452 (Rev. 7/2015)

This PCS (Medical Necessity Form) is for all wheelchair transports.



5484 State Route 49 South
Greenville, Ohio 45331
Dispatch: 937-548-2800 Toll Free: 866-548-2818
Fax: 937-548-2828

PATIENT "CLOSEST APPROPRIATE FACILITY" QUESTIONNAIRE

Patient's Name	Date of Transport	Incident Number
----------------	-------------------	-----------------

INFORMATION: Medicare and a host of other insurance companies only cover ambulance transportation to the "closest appropriate facility." Simply put, unless we have documentation to the contrary, if "Hospital A" offers the same service and/or physician specialty as "Hospital B," and we transport to "Hospital B" which is of greater distance simply because the patient has a developed relationship with a physician at that facility, the referring physician chose that facility for the patient and/or the patient desires to go to the more distant facility. Medicare and some other insurance companies require us to charge the patient for the additional mileage traveled beyond "Hospital A" in the absence of documentation that "Hospital B" was the closest appropriate hospital that met the medical needs of the patient at the time of the needed transport. Therefore, it's essential for us to know in cases where we may have been forced to travel farther, the reason the patient didn't go to the closer facility was because there were no beds available, a team of physician specialists/equipment needed to care for the patient wasn't immediately available at the closer location, there was no physician at the closer facility willing to accept the patient, etc. With that said, we ask you the following questions:

1. What is your medical diagnosis?

2. Were you ever seen by a local physician for this diagnosis?

Yes No

2a. If yes, who treated you locally? (Name of physician and hospital)

2b. If no, who initially treated you for this condition or how were you referred?

3. How long have you been going to this specialty physician[s]/hospital? (Years, year diagnoses etc.)

4. Were any type treatments done locally before you were referred?
(What treatments do you recall and were they successful?)

Yes No

5. How did it come about that you were referred to the specialty physician/hospital in which you were/are being transferred?

6. What services/physician specialty for treatment that is available at the for distant hospital, that isn't otherwise available any place closer?

7. Has any hospital or specialty physician locally been willing to oversee your care and/or treat you since being referred to the more distant location?

Yes No

7a. If yes, please specify who and provide additional details:

Please use the back of this form if additional space is needed

This form is completed for **ALL transports that are over 50 miles.**

Certification of Medical Appropriateness



Patient's Name

Date of Transport

Incident Number

Dear Physician:

Medicare and a host of other insurance companies only cover ambulance transportation to the "closest appropriate facility." Simply put, unless we have documentation to the contrary, if "Hospital A" offers the same service and/or physician specialty as "Hospital B," and we transport to "Hospital B" which is of greater distance simply because the patient has a developed relationship with a physician at that facility, the referring physician chose that facility for the patient and/or the patient desires to go to the more distant facility, Medicare and some other insurance companies require us to charge the patient for the additional mileage traveled beyond "Hospital A" in the absence of documentation that "Hospital B" was the closest appropriate hospital that met the medical needs of the patient at the time of the needed transport. Therefore, it is essential for us to know, in cases where we may have been asked to travel farther, the circumstances that influenced your decision for the patient to be transported to a facility of greater distance. With that said, we ask you the following questions:

1. What is the patient's medical diagnosis for which they are being transferred? _____
2. Could this diagnosis be managed at a closer facility than the one the patient is being transferred to? Yes No
3. The services, equipment, and / or physician specialty that is available at the receiving facility and not available at the call location is: (Check all that apply)

<input type="checkbox"/> Inpatient Adult Behavioral Health Services	Diagnostic Radiology	<input type="checkbox"/> Oncology Services	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> Inpatient Youth Behavioral Health Services	<input type="checkbox"/> CT <input type="checkbox"/> X-ray	<input type="checkbox"/> Pediatric Services	<input type="checkbox"/> Rheumatologist
<input type="checkbox"/> Inpatient Geriatric Behavioral Health Services	<input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound	<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Urologist
<input type="checkbox"/> Inpatient Hemodialysis Unit	<input type="checkbox"/> _____	<input type="checkbox"/> Cardiologist	<input type="checkbox"/> General Surgeon
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Venous Doppler	<input type="checkbox"/> Invasive Cardiac Services	<input type="checkbox"/> Hand Surgeon
<input type="checkbox"/> Skilled Nursing Services	<input type="checkbox"/> Nuclear Radiology	<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Orthopedic Surgeon
<input type="checkbox"/> Assisted Living Services	<input type="checkbox"/> Oncology Radiation	<input type="checkbox"/> Endocrinologist	<input type="checkbox"/> Plastic/Reconstructive Surgeon
<input type="checkbox"/> Home Health Services	<input type="checkbox"/> STAT Blood Work	<input type="checkbox"/> Family Physician	<input type="checkbox"/> Thoracic Surgeon
<input type="checkbox"/> Residential Institution	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Vascular Surgeon
	<input type="checkbox"/> Intensive Care Bed	<input type="checkbox"/> Hematologist	<input type="checkbox"/> Psychiatrist
			<input type="checkbox"/> Other: _____

4. Additional circumstances that led to this patient being transferred to this specific hospital included: (Check all that apply)

<input type="checkbox"/> No beds were available at a closer facility	<input type="checkbox"/> Subspecialty intervention for vascular emergency
<input type="checkbox"/> A team of physician specialists/equipment needed to care for the patient wasn't immediately available at the closer location	<input type="checkbox"/> Diagnostics or intervention for a neurological or injury or impairment
<input type="checkbox"/> Due to the complexity of the case, there was no physician at the closer facility willing to accept the patient	<input type="checkbox"/> Surgical or medical specialist for gastro-intestinal injury or disease
<input type="checkbox"/> Subspecialty intervention for a multi-system trauma	<input type="checkbox"/> Re-implantation team for an extremity injury
<input type="checkbox"/> Subspecialty intervention for an orthopedic injury	<input type="checkbox"/> Burn center care for thermal, chemical or electrical injuries
<input type="checkbox"/> Specialized pediatric care for a pediatric injury/illness	<input type="checkbox"/> Invasive diagnostics/intervention for a cardio-thoracic condition or disease
<input type="checkbox"/> High-risk obstetrical services	<input type="checkbox"/> Continuity of care related to _____
<input type="checkbox"/> Hyperbaric treatment for toxic exposure or other emergent injury	<input type="checkbox"/> Other (please describe) _____
<input type="checkbox"/> Level III nursery care for neonatal emergency	
<input type="checkbox"/> Sepsis	

I certify I have completed this report based upon the information available to me at the time of the patient's transport. I further affirm that the information contained in the sections above represent an accurate assessment of the beneficiary's medically necessary need(s) for the above mentioned ALS/BLS Ambulance Transportation Services.

Printed first and last name of physician ordering ambulance transportation must be specified below:

MD DO

For non-repetitive, unscheduled ambulance transports, this form may be signed by any of the following, if the attending physician is unavailable to sign (please check the appropriate box below)

Printed Physician's first and last name and check credentials

Printed Healthcare Professional's first and last name and credentials

Physician's signature

Date

Healthcare Professional's signature

Date



Physician Assistant Clinical Nurse Specialist Registered Nurse
 Nurse Practitioner Discharge Planner

Completed forms may be given to Spirit Medical Transport personnel at the time of transport or Fax directly to 937-548-2826
Please use the back of this form if additional space is needed

This form is completed for ambulance transports that are over 50 miles.